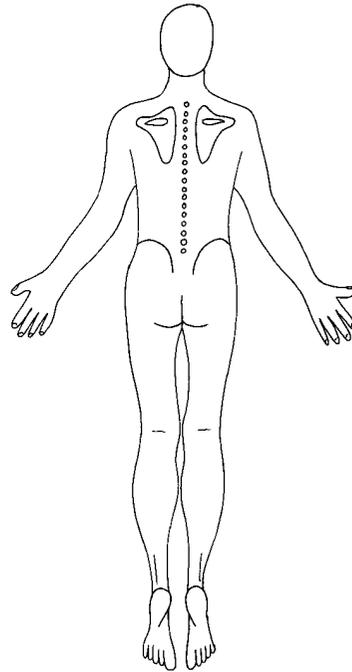
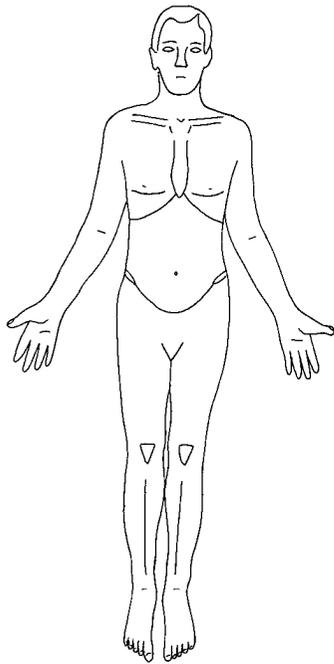


Medication	YES	NO
Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>

Please list ALL the medication you are taking

Indicate on the pictures where you get your symptoms, for example pain, pins and needles, numbness



Please make sure you have filled in all parts of the form

Signature _____

Date _____

Please return this form to:

Appointments Officer, Physiotherapy Department,

Morrison Hospital, Heol Maes Eglwys, Morrison, Swansea, SA6 6NL

If your symptoms should change, please contact the physiotherapy department on 01792 703124 or see your GP

Physiotherapy Service Self Referral Form

This form should only be used for patients wishing to have physiotherapy for musculoskeletal problems (back/neck pain, joint pain, soft tissue injuries)

If you are under the age of 18, or wish to have treatment for a lung or breathing problem, a neurological problem or an obstetric/gynaecological problem, please see your Health Practitioner

This form will be used to determine how your referral is processed. Please ensure you:

- Use a **BLACK** Pen
- Use **BLOCK CAPITALS**
- Complete **ALL** sections of the form

Incomplete forms will be returned to you which will cause a delay in the management of your problem. Once received, the form will be reviewed and placed on a waiting list.

Full Name _____

Address _____

Post Code _____

Date of Birth: ____ / ____ / ____

Your Contact Telephone Numbers

Can we leave a message?

Home _____

Yes / No

GP Name _____

Work _____

Yes / No

Practice _____

Mobile _____

Yes / No

Please give a brief description of your symptoms, or why you wish to see a physiotherapist

How long have you had this problem? Days ____ Weeks ____ Months ____ Years ____

How did it start? (Just came on, injury, fall, long term problem etc)

Are you in pain all the time or does it come and go?

Pain all the time

Comes and goes

How often do you have the pain? _____

What makes the pain WORSE?

What makes the pain BETTER?

Is it generally worse? *Tick answer that applies most*

In the morning In the Afternoon In the evening At night No pattern

Have you had treatment / physiotherapy for this condition in the past? **Yes / No**
(if YES, please give details)

Have you had any X-rays or other tests? **Yes / No** *(if YES, please give details/ results)*

Have you had this problem before? **Yes / No** *(if YES, please give details)*

If this is a problem with your joints:

Does your joint? **YES NO YES NO YES NO YES NO**
Give Way Click Lock Swell

Are you off work or unable to care for a dependant because of this problem? **Yes / No**
(if yes, please give details)

Please indicate any activities you are unable to do because of this problem

What are your expectations from Physiotherapy?

SINCE THE ONSET OF THIS PROBLEM, do any of the following apply to you?

If you have the symptoms please tick **YES**—If you do not have the symptoms please tick **NO**

	YES	NO		YES	NO
Severe Pain at Night (Wakes you up)	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Does coughing change your symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Problems Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with speaking	<input type="checkbox"/>	<input type="checkbox"/>	Does Sneezing change your symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with walking	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>
Pins and Needles anywhere	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Numbness Anywhere	<input type="checkbox"/>	<input type="checkbox"/>	Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>

If you have ticked **YES** to any of these symptoms, and you **HAVE NOT** seen a doctor for this symptom, please call **Physio Direct** (01792 487453) OR **NHS Direct** on (0845 45 46 47)

DO NOT send in this form until you have sought further advice
Please tick box to confirm you have sought further advice if indicated

SINCE THE ONSET OF THIS PROBLEM Do any of the following Statements apply?

	YES	NO
Bladder Problems —a difficulty in passing water or feeling you cannot empty your bladder	<input type="checkbox"/>	<input type="checkbox"/>
Bowel problems —a loss of bowel control (soiling yourself)	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>

If you have ticked **YES** to any of these symptoms, and you **HAVE NOT** seen a doctor for this symptom, it is essential you arrange an **URGENT** appointment with your **GP** or call **NHS Direct** on (0845 45 46 47) or attend your local **A&E Department**

DO NOT SEND IN THIS FORM UNTIL YOU HAVE SOUGHT FURTHER ADVICE

General Health	YES	NO		YES	NO		YES	NO
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Lung / Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fractures / Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered YES to any of the above or have any other medical problems, please provide further details here: